MDHHS Revised Contact Tracing & Case Investigation Strategy

Operational FAQ

January 2022

The following questions have been submitted by local health departments and the responses are provided by MDHHS. For the purposes of this FAQ, "we", "us", "you" and "our" refers to local health departments.

Do we still need to enter all cases for surveillance purposes?

Yes. Confirmed and probable cases reported to public health need to be entered into the MDSS along with core demographic information.

So, what are next steps to complete them? Do we use PEG or just complete in MDSS?

Cases will need to be completed in MDSS. Those can be closed out centrally, with a script, as was the case earlier this year with all open 2020 cases. MDHHS will work to modify and adjust the cadence of running the scripts to minimize impact on LHD workflows. Additionally, MDHHS is starting a PEG user group to discuss optimizing how PEG cases come into MDSS.

Is the plan for us to tackle outbreaks as we have been – with an outbreak identifier on each case?

Yes. The summary of the outbreak should be documented in the MDSS aggregate form. All individual outbreak-associated cases should have the same outbreak name as the outbreak name in the aggregate case report form.

Is there a plan to use PEG to send info to cases or will info just be shared through our strategies (e.g. we can send out to all our business/school/community contacts through email, texts, etc)?

PEG is currently sending information to all cases in Michigan except for a few health departments who asked to be exempted because they use Tiger Connect. PEG is configured to provide education and allow for limited data collection. MDHHS is starting a PEG user group to discuss optimizing how PEG is used to communicate to the public.

What information is still needed in MDSS? Will we still be entering demographic data on individual cases?

Yes. Core demographic information is still required for each manually entered case. This is the type of data that is included with electronic case referrals. This includes NAME; DOB; SEX; RACE; ETHNICITY; ADDRESS; SPECIMEN COLLECTION (TEST) DATE

For rapid tests reported by schools, urgent cares, congregate facilities, etc., can we use the New Aggregate Reporting on MDSS rather than individual case entry? Could probables be reported in aggregate?

No. Positive test results are **not** to be reported in aggregate. However, there is a bulk load option to upload CSV files with this data on the antigen result entry portal. These results will then be processed into the MDSS in a similar fashion as ELRs.

Currently people report home tests to the LHD through an online form on our website – should these be entered into MDSS?

That is at the discretion of the LHD. If you have available resources to do so, and accessible information, these records may be entered into the MDSS as "Suspect" cases. You may want to consider an autoreply that includes an educational message, similar to the PEG education wording.

What is the plan for Traceforce (TF)? Are you considering having TF make contact through text/phone call to positive cases instead of close contacts? Is the plan to keep Traceforce staffed? If so, could they push info out and take call backs for further instruction? If not, maybe we can use PEG differently at the local level?
Traceforce will be maintained along with a small core of surge tracers. They will be used specifically for surge needs for K-12 contacts and contacts of high-risk outbreaks or setting. MDHHS plans to advertise the TF hotline number and 211 for contacts so any contact can call in and get quarantine information but based on previous conservations there hasn't been a lot of appetite for texting contacts without consent.

If we are no longer completing case investigations in general, can we use PEG differently – ie; to push out messaging regarding isolation/quarantine with links to documents/HD resources, # to call, etc. (kind of like how some of us used PEG for vaccination scheduling at one time).
PEG currently does this, but MDHHS is starting a PEG user group to discuss optimizing how PEG messages are received by the public.

Would the state pivot to this rather than using PEG for case investigations so each LHD doesn't have to contract with them separately?
We already have a single contract with PEG and are doing optimizations for the whole state. Many local health jurisdictions have already employed PEG to collect data and provide educational messages via text. MDHHS is starting a PEG user group to discuss optimizing how PEG cases send information to the public.

It would be helpful to develop a process map for the new changes – how does a case become a case and where does it go from there? We would be happy to help on a workgroup!
Cases become "cases" upon referral of laboratory confirmation. That was a modification to the COVID case flow made very early in the process. These cases are now being referred to PEG to provide patient education and resources as well as a data collection functionality. Previously, once returned from PEG, LHD review was necessary, but that is being changed. In the absence of LHD review, the cases will flow from PEG into MDSS after 7 days. The status of the returned cases is being changed to completed en masse by a MDHHS script run against the MDSS database.

If some of these changes were made – will the autodump still work between PEG and MDSS? An ideal process might be:

- **A positive case is entered into MDSS**
- **It kicks to PEG**
- **PEG sends individualized agency message**
- **Comes back to MDSS with completed status**

This is all currently the process for every health department in MI except for a few using Tiger Connect except for the final step (completed status)—MDHHS can discuss if that is possible. The final step is discussed above where bulk cases can be completed at the statewide level. MDHHS is starting a PEG user group to discuss optimizing how PEG cases come into MDSS.

Prior to completing a case in MDSS, does the Investigator need to reassign it to themselves?
No, not if the user has a role in MDSS that allows them to complete cases. Considering the possibility of bulk completing cases at the statewide level, this may not be relevant or necessary.

Right now everyone is assigned to a clerical data entry person from when it is entered. If we don't want it to be the data entry person but want it to be an RN, then could we have them initially assign it to someone else? Right now, it can take an extra couple minutes to reassign it to an investigator (seems not important since we are not investigating anyway)
The LHD can set up default recipients of new referrals in the MDSS.

Since we are still asking schools to contact trace, if they provide us a list of close contacts do we need to enter those close contacts into MDSS for tracing via traceforce (minimal for those with universal masking or offering test to stay, but could have some that refuse to follow such guidance)? You can use the OMS upload to get those classroom contacts into TF and bypass MDSS. The template is on www.michigan.gov/cdinfo. However, if you know that the school has capacity to notify the contacts of their exposure you are not required to receive the lists and upload them.

If we bulk upload school contacts to OMS, will they still be transferred over to Traceforce? Yes

Will school contacts still get a call from Traceforce? Yes

If they do not receive a call but decide to call the hotline will the person on the other end look for a record and advise them on quarantine based on that information? (We are trying to determine if it is still worth uploading these sheets) Yes

Any thought of having Traceforce send a text message to people names as close contacts? It might be helpful for it to say something along the lines of "You have been named as a close contact to someone who tested positive for COVID. If you need information on quarantine, please call (Hotline Number)." Due to FTC regulations, contacts have not been sent texts without their consent thus far – this can be reviewed again. Currently, MDHHS promotes the website tellyourcontacts.org in MDHHS materials.

If a LHD investigates an issue in a school that they consider to be "higher risk" (e.g., a positive case on a sports team), then do CT/CI efforts needs to extend into the rest of the school? CI efforts in schools target the cases who have tested positive. If during the course of an investigation, additional close contacts of the cases are identified, they should also be enumerated and notified.

LHDs are needing daycare/childcare guidance asap. They understand that MDHHS is awaiting further guidance from CDC, but it is critical to get this out as soon as possible. Discussions are happening now with LARA; guidance will be forthcoming in upcoming days, goal is by February 4, 2022.

Should close contacts in schools still be entered into MDSS? If you are confident that the school has capacity and is notifying all close contacts, you do not need to enter them into MDSS or OMS at all. If you do have classroom lists, however, we think it is more efficient to use the OMS upload.

Staff are looking for more specifics about the behind-the-scenes process and how to get to the place MDHHS is wanting them to get with CT/CI. Looking for a roadmap with more detail and a new SOP. SOP is currently being updated. New processes are described above.

How will the answers to these questions gathered today be communicated back to LHD staff? MDHHS will post on www.michigan.gov/cdinfo.

LHDs are asked for outbreak information in the SITREP, but this information is likely under-reported. The outbreak data reported on the MDHHS website does not look like it is complete. How can LHDs provide better data to MDHHS on outbreaks?
There will be an updated protocol that will be released in upcoming days.

If Traceforce staff still calls school cases, what cut-off date will be will used? Some schools are choosing to continue 10-day quarantine. Will cases still be called after day 5? TF will default to 5 days. If LHDs want certain people moved to 10 days they will have to manually change the end monitoring date in TF before 9 am. They will not be called after day 5 unless the date is manually changed.

Staff are looking for materials they can provide to schools so school staff can provide consistent messaging about change in CT/CI? When to return to school? What to do if positive/exposed? There are some updated materials on www.michigan.gov/ContainCOVID. Additionally, an FAQ for K12 Schools to clarify quarantine and isolation questions is available here: https://www.michigan.gov/documents/coronavirus/K-12_Isolation__Quarantine_Guidance_-_FAQ_Final_746828_7.pdf

How is reporting going to look going forward? Will aggregate case reporting be used? It is unclear what the long-term strategy will be on case reporting. At this time, probable and confirmed cases must be individually reported (also answered above). Outbreak investigation summaries should also be documented in the MDSS aggregate case report form.

How do LHDs help schools know who can come back to school in cases of community transition? If Traceforce is not following household contacts, how does the school handle a case when they know a student has been exposed in their household rather than in the school setting?
When students or staff are exposed in a household or community (non-school based) setting they should follow the general population guidance found at Michigan.gov/ContainCOVID.

Would like better clarification of expectations for schools? What is the LHD responsible for? What is the school responsible for?
When schools learn of a confirmed case, schools are responsible for identifying and notifying close contacts of that individual. LHD's are responsible for reviewing incoming data, notifying schools of cases and clusters that they are made aware of, investigation of cases, outbreaks, and contact tracing as appropriate or requesting MDHHS assistance.

Should schools contact tracing home tests (or suspects per definition). And if they should be reporting those home tests parent report in their total numbers on their dashboards. Many don't differentiate between probable/confirmed, so then suspect adds another level they don't know how to manage or report.
There are no public health or school reporting requirements for non-proctored antigen testing (i.e., at-home tests) that create suspect cases. If suspect cases from at-home testing are reported, schools or LHDs may opt to use this as situational awareness for their investigation. Per CSTE case definition, a symptomatic case with a known exposure meets the definition of a Probable case, even in the absence of proctored testing. Probable cases would receive PEG messaging while Suspect cases currently do not.